

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-000349

AMENDED

Registration District No.

042

Primary Registration District No.

1000

Registrar's No.

44

STATE FILE NUMBER

FILED JAN 22 1962

| | | | |
|---|---|---|------------------------------|
| 1. PLACE OF DEATH a. COUNTY Buchanan | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY Buchanan | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph | | c. CITY OR TOWN St Joseph, | |
| Length of stay in 1b 37yrs | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Mo. Methodist Hospital | | d. STREET ADDRESS 817 W Valley | |
| Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Jean Griffin | | 4. DATE OF DEATH Jan 12, 1962 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH Feb 5, 1885 |
| 9. AGE (last birthday) 76 | | IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Re. Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY Swift & Co | |
| 11. BIRTHPLACE (City and state or country) Maysville, Mo | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | |
| 13a. FATHER'S NAME Unk | | 13b. MOTHER'S MAIDEN NAME Josephine- ? | |
| 14. NAME OF HUSBAND OR WIFE Gracie Griffin | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address Mildred Brown St. Joseph Mo | |
| 18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Thrombosis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Cerebral Arteriosclerosis DUE TO (c) Arteriosclerosis | | INTERVAL BETWEEN ONSET AND DEATH sudden unknown unknown | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) | |
| 20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | |
| 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 20f. CITY, TOWN, OR LOCATION COUNTY STATE | |
| 21. I attended the deceased from 1/12/62 to 1/12/62 and last saw her alive on 1/12/62 Death occurred at 8:05 P.M. m on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Degree or title) Sharon E. Waggoner M.D. | | 22b. ADDRESS 301 Illinois Ave St. Joseph, Missouri | |
| 22c. DATE SIGNED 1/16/62 | | 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | |
| 23b. DATE 1/15/62 | | 23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery St. Joseph, Mo | |
| 23d. LOCATION (City, town, or county) (State) | | 24. FUNERAL DIRECTOR ADDRESS St. St. Joseph, Mo | |
| 25. DATE RECD. BY LOCAL REG. Jan. 19, 1962 | | 26. REGISTRAR'S SIGNATURE Mrs. Clark Goodell | |

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
~~or by~~ _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____

Licensed Embalmer No. 3986

P. O. Address St. Joseph, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.